



Advising the Congress on Medicare issues

Increasing participation in the Medicare savings programs and the low-income drug subsidy

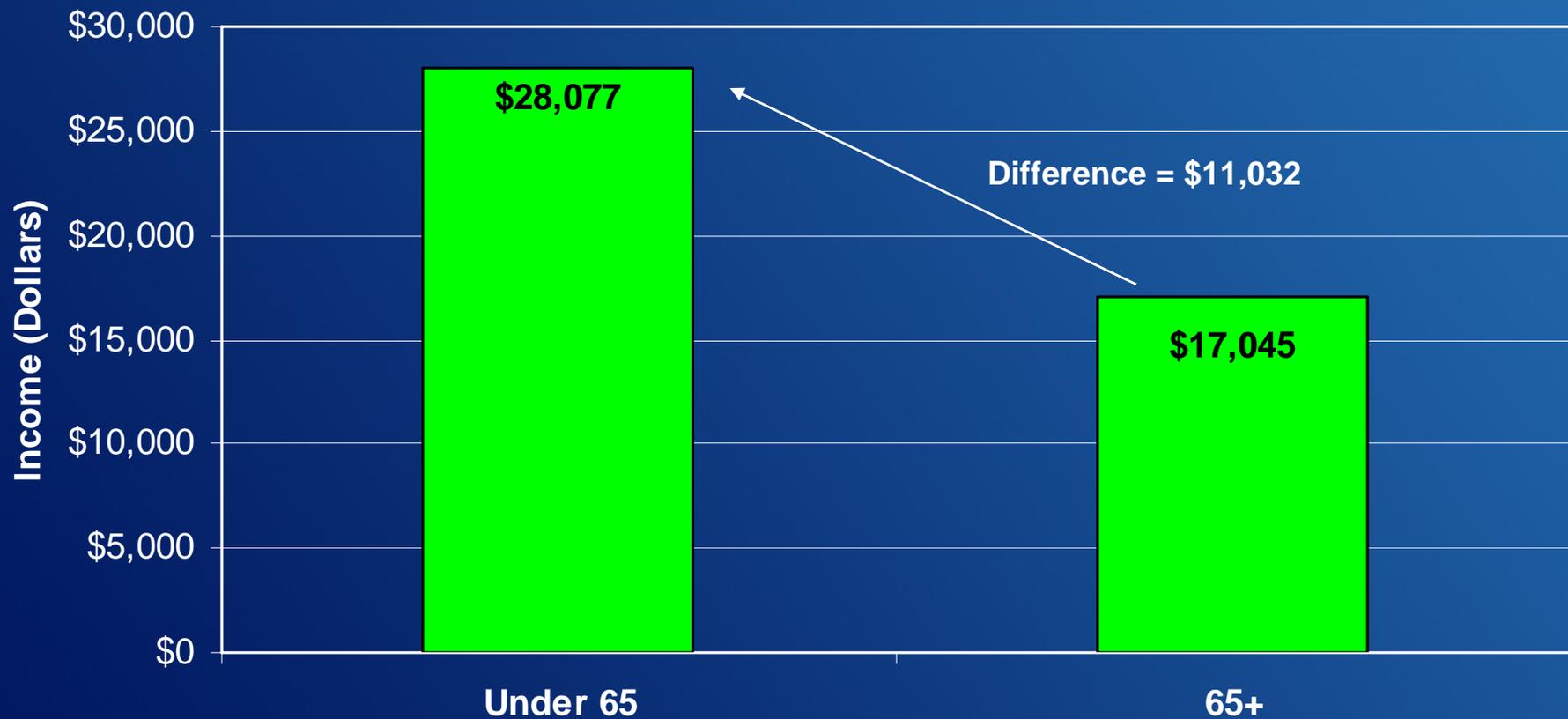
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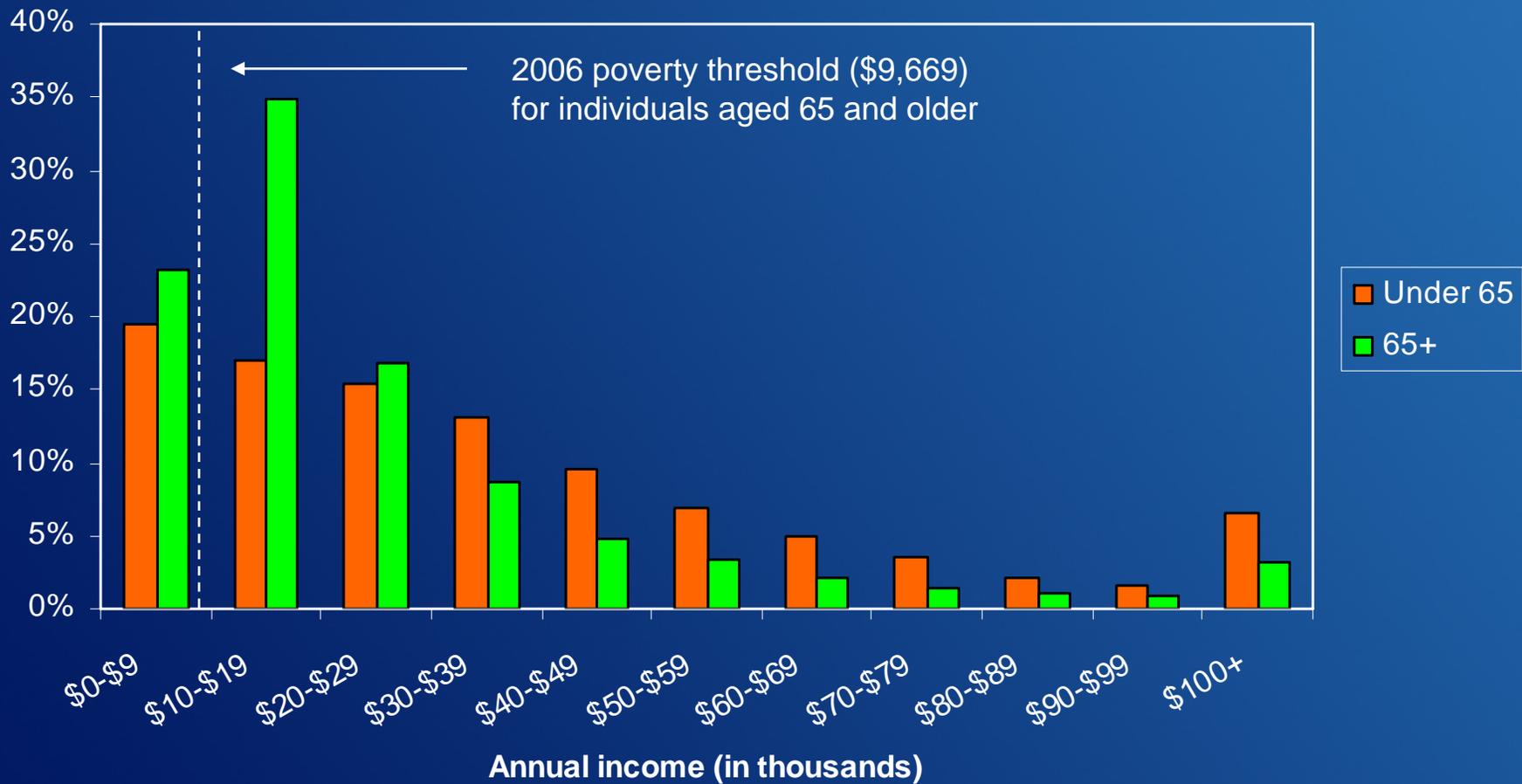
Key findings

- Medicare beneficiaries typically have lower incomes and higher out-of-pocket health care costs than the rest of the population
- Increasing participation in programs that provide help to beneficiaries with limited incomes has proven difficult
- Targeted outreach and administrative simplification can be effective strategies

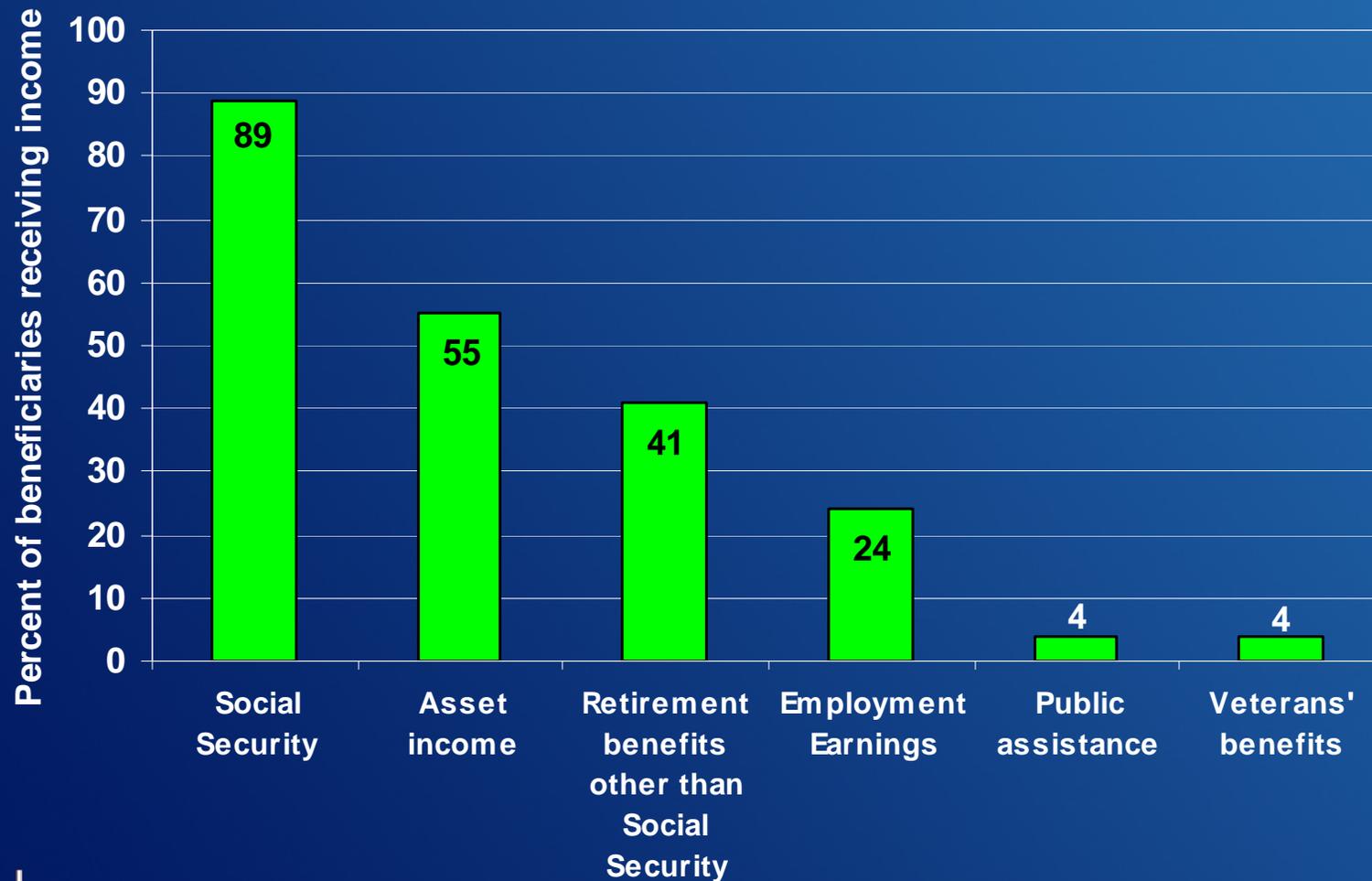
2006 Person-level median income



Income distribution for individuals above and below 65 years



Percentage of Medicare eligibles receiving income from specified source in 2004



Median out-of-pocket health care spending as a percent of income for one-person households, 1998-2003



MSP enrollment reduces health care avoidance

- High out-of-pocket health care costs may motivate Medicare beneficiaries, especially those near the poverty line, to avoid necessary health care
- Overall self-reported rates of avoidance among low-income seniors were:
 - 30.9 percent for physician visits
 - 20.7 percent for hospital visits
 - 26.0 percent for prescription filling
- QMB enrollees were half as likely as non-enrollees to report physician avoidance

Why don't more beneficiaries participate in these programs?

- Lack of awareness of the programs
- Complexity of the application and enrollment processes
- Reluctance to go to state Medicaid offices because of perceived welfare stigma

Efforts to increase participation have achieved limited but substantial results

- One initiative gave 5 states up to \$450,000 over a 3 year period to boost enrollment
- Successful efforts targeted individuals and provided specific information on how and where to get help with enrollment process
- Projects included contacting participants in other programs, using data from SSA to identify and recruit participants

SHIPs have limited resources to counsel beneficiaries

- SHIPs could use additional money to:
 - train local volunteers on program eligibility
 - purchase computer laptops to submit beneficiary applications from homes, churches, and other community sites
 - provide written materials and translators for beneficiaries who are not English-speakers
 - provide more rural outreach

Eligibility criteria for MSP programs

MSP program	Income limit	Covered costs and services
QMB	<100% of poverty	Medicare premiums & cost-sharing
SLMB	100-120% of poverty	Medicare premiums
QI	120-135% of poverty	Medicare premiums

Note: All MSP programs have an asset limit of \$4,000/\$6,000 per individual/couple

Eligibility criteria for low-income drug subsidy (LIS)

Beneficiary category	Income	Asset limit, 2007	Covered costs and services
Full subsidy	<135% of poverty	\$7,620/ \$12,190	No premium, deductible, \$2.15-\$5.35 copays, no copays after drug spending reaches \$5,100
Limited subsidy	<150% of poverty	\$11,710/ \$23,410	Sliding scale (25-100% of low-income benchmark premium), \$53 deductible, 15% coinsurance, \$2.15-5.35 copay after drug spending reaches \$5,100
Dual eligibles, QMB, SLMB, QI	Deemed eligible	Deemed eligible	No premium, deductible, \$2.15-\$5.35 copays, no copays after drug spending reaches \$5,400

Simplifying MSP enrollment

- The Congress set income and asset criteria for LIS at a higher level than MSP
- MSP asset criteria have not been revised since 1989 when the first program was established
- Many states have used their authority to effectively raise MSP income or asset levels

The role of SSA

- SSA is responsible for determining LIS eligibility for those individuals who apply for the subsidy
- Beneficiaries can apply for LIS without facing possible stigma associated with applying at a Medicaid office
- If MSP and LIS eligibility were based on same criteria, SSA could screen and enroll beneficiaries for both programs at the same time